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No. 10-1014

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In the Supreme Court of the United States

VIRGINIA, EX REL. KENNETH T. CUCCINELLI, II,
ATTORNEY GENERAL OF VIRGINIA, PETITIONER

v.

KATHLEEN SEBELIUS, SECRETARY OF HEALTH AND
HUMAN SERVICES

ON PETITION FOR A WRIT OF CERTIORARI
BEFORE JUDGMENT
TO THE UNITED STATES COURT OF APPEALS
FOR THE FOURTH CIRCUIT

BRIEF FOR THE RESPONDENT IN OPPOSITION

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QUESTION PRESENTED

Beginning in 2014, the minimum coverage provision of the Patient Protection and Affordable Care Act (Affordable Care Act), will require non-exempted individuals to maintain a minimum level of health insurance or pay a tax penalty. Pub. L. No. 111-148, § 1501(b), 124 Stat. 244-249 (to be codified at 26 U.S.C. 5000A). Constitutional challenges to the provision are now pending in four courts of appeals, three of which have expedited proceedings—including in this very case. The question presented is whether the Court should grant certiorari before judgment in the court of appeals to decide:

1. Whether the district court erred in holding that petitioner could establish standing to challenge the minimum coverage provision by enacting a law that declares that no Virginia resident "shall be required to obtain or maintain" an individual insurance policy. Va. Code Ann. § 38.2-3430.1:1 (Supp. 2010).

2. Whether the district court erred in holding that the minimum coverage provision is not a valid exercise of Congress's Article I powers.

3. Whether the district court erred in holding that the minimum coverage provision is severable from other provisions of the Affordable Care Act.

4. Whether the district court erred in denying an injunction.

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In the Supreme Court of the United States

No. 10-1014

VIRGINIA, EX REL. KENNETH T. CUCCINELLI, II, ATTORNEY GENERAL OF VIRGINIA, PETITIONER

v.

KATHLEEN SEBELIUS, SECRETARY OF HEALTH AND HUMAN SERVICES

ON PETITION FOR A WRIT OF CERTIORARI BEFORE JUDGMENT TO THE UNITED STATES COURT OF APPEALS FOR THE FOURTH CIRCUIT

BRIEF FOR THE RESPONDENT IN OPPOSITION

OPINIONS BELOW

The opinion of the district court denying respondent's motion to dismiss (Pet. App. 54-89) is reported at 702 F. Supp. 2d 598. The opinion of the district court granting summary judgment for petitioner in part (Pet. App. 1-53) is reported at 728 F. Supp. 2d 768.

JURISDICTION

The judgment of the district court was entered on December 13, 2010. Respondent filed a notice of appeal on January 18, 2011. Petitioner also filed a notice of appeal on January 18, 2011. The petition for a writ of certiorari before judgment was filed on February 8, 2011.

This Court's jurisdiction is invoked under 28 U.S.C. 1254(1) and 2101(e).

STATEMENT

The Virginia General Assembly enacted a statute declaring that its residents do not have to comply with a provision of the Patient Protection and Affordable Care Act (Affordable Care Act or Act), Pub. L. No. 111-148, 124 Stat. 119, requiring non-exempted individuals to maintain a minimum level of health insurance or pay a tax penalty. Petitioner then used its state statute to sue respondent in an effort to secure a declaration that its state statute is valid because the federal minimum coverage provision falls outside Congress's enumerated powers under Article I of the Constitution. The district court found that petitioner had standing and granted petitioner summary judgment on its constitutional claim. Both parties appealed, and, on a joint motion by respondent and petitioner, the court of appeals expedited briefing in the case and will hear oral argument on May 10. Petitioner nonetheless seeks to bypass that process of orderly appellate review by asking this Court to grant certiorari before judgment. The petition for a writ of certiorari before judgment should be denied.

1. Congress enacted the Affordable Care Act to ameliorate the longstanding crisis in the interstate market for health care services, which accounts for more than 17% of the Nation's gross domestic product. Among other problems, millions of people without health insurance consume health care services for which they do not fully pay. These uncompensated costs—totaling $43 billion in 2008—are shifted to health care providers in the interstate health care market. Providers pass on much of this cost to private health insurance companies,

which also operate interstate. The result is higher premiums, which, in turn, make insurance unaffordable to even more people. See generally Act §§ 1501(a) and (a)(2), 10106(a), 124 Stat. 242, 243, 907 (to be codified at 42 U.S.C. 18091(a) and (a)(2)) (congressional findings). At the same time, insurance companies use restrictive underwriting practices to deny coverage or charge unaffordable premiums to millions of people because they have pre-existing medical conditions.[1]

a. The Affordable Care Act includes several measures designed to make affordable, comprehensive health insurance coverage widely available, protect consumers from restrictive insurance underwriting practices, and reduce the uncompensated costs of medical care obtained by the uninsured, which are borne by others in the health care market.

First, the Act builds upon the existing nationwide system of employer-based health insurance that is the principal private mechanism for health care financing. The Act establishes tax incentives for small businesses to purchase health insurance for their employees, §§ 1421(a), 10105(e), 124 Stat. 237, 906 (to be codified at 26 U.S.C. 45R), and, under certain circumstances, prescribes tax penalties starting in 2014 for large employers that do not offer full-time employees adequate coverage. §§ 1513(a), 10106(e) and (f), 10108(i)(1)(A), 124 Stat. 253, 910, 914; Health Care and Education Reconciliation Act of 2010 (Reconciliation Act), Pub. L. No. 111-152, § 1003, 124 Stat. 1033 (to be codified at 26 U.S.C. 4980H).

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[1] See U.S. Dep't of Health & Human Servs., *At Risk: Pre-Existing Conditions Could Affect 1 in 2 Americans*, HealthCare.gov (2011), http://www.healthcare.gov/center/reports/preexisting.html.

Second, the Act provides for the creation of health insurance exchanges to allow individuals, families, and small businesses to use the leverage of collective buying power to obtain prices that are competitive with those of large-employer group plans. §§ 1311, 10104(e)-(h), 10203(a), 124 Stat. 173, 900-901, 927 (to be codified at 42 U.S.C. 18031).

Third, for individuals and families with household income between 133% and 400% of the federal poverty level who purchase health insurance coverage through an exchange, the Act establishes federal tax credits that can offset all or part of payments for the insurance premiums. §§ 1401(a), 10105(a)-(c), 10108(h)(1), 124 Stat. 213, 906, 914; Reconciliation Act §§ 1001(a), 1004(a)(1)(A) and (a)(2)(A), 124 Stat. 1030, 1034 (to be codified at 26 U.S.C. 36B). In addition, Congress expanded eligibility for Medicaid to cover individuals with income below 133% of the federal poverty level. § 2001(a)(1)(C), 124 Stat. 271 (to be codified at 42 U.S.C. 1396a(a)(10)(A)(i)(VIII)). The Act provides that the federal government will pay for 100% of the expenditures required to cover recipients made newly eligible under the Act through 2016, gradually declining to 90% in 2020 and beyond—far above the usual federal matching rates under Medicaid. § 2001(a)(3)(B), 124 Stat. 272; Reconciliation Act, § 1201(1)(B), 124 Stat. 1051 (to be codified at 42 U.S.C. 1396d(y)(1)).

Fourth, the Act imposes new regulations on insurance companies to protect individuals from industry practices that have prevented people from obtaining and keeping health insurance. The Act bars insurance companies from refusing to cover individuals because of a pre-existing medical condition, § 1201(4), 124 Stat. 155 (to be codified at 42 U.S.C. 300gg-1(a), 300gg-3(a)), can-

celing insurance absent fraud or intentional misrepresentation of material fact, § 1001(5), 124 Stat. 131 (to be codified at 42 U.S.C. 300gg-12), charging higher premiums based on a person's medical history, § 1201(3), 124 Stat. 154 (to be codified at 42 U.S.C. 300gg), and placing lifetime dollar caps on the benefits of a policyholder for which the insurer will pay, §§ 1001(5), 10101(a), 124 Stat. 130, 883 (to be codified at 42 U.S.C. 300gg-11).

Finally, the Act amends the Internal Revenue Code to provide that, starting in 2014, a non-exempted individual who fails to maintain a minimum level of health insurance must pay a tax penalty. § 1501(b), 124 Stat. 244-249 (to be codified at 26 U.S.C. 5000A).[2] Under this minimum coverage provision, individuals who are not required to file income tax returns for a given year are not required to pay the penalty. § 1501(b), 124 Stat. 247; Reconciliation Act, § 1002(b)(2), 124 Stat. 1032 (to be codified at 26 U.S.C. 5000A(e)(2)). The amount of any penalty is calculated in part by reference to household income for federal income tax purposes; it is reported on the individual's federal income tax return for the taxable year; and it is assessed and collected in the same manner as certain other federal tax penalties. §§ 1501(b), 10106(b)(2), 124 Stat. 244-245, 249, 909; Reconciliation Act, § 1002(a)(1), 124 Stat. 1032 (to be codified at 26 U.S.C. 5000A(b)(2), (c)(1), (c)(2) and (g)).

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[2] This insurance requirement may be satisfied through enrollment in an employer-sponsored insurance plan, an individual market plan including a plan offered through a new health insurance exchange, a grandfathered health plan, certain government-sponsored programs such as Medicare, Medicaid, or TRICARE, or similar coverage recognized by the Secretary of Health and Human Services in coordination with the Secretary of the Treasury. Act § 1501(b), 124 Stat. 248 (to be codified at 26 U.S.C. 5000A(f)).

b. In enacting the Affordable Care Act in general, and the minimum coverage provision in particular, Congress recognized that it confronted a market that differs in significant respects from all others.

First, participation in the market for health care is essentially universal, and an individual's need for expensive medical care is unpredictable. Nearly everyone will require health care services at some point in his or her life, and "[m]ost medical expenses for people under 65" result "from the 'bolt-from-the-blue' event of an accident, a stroke, or a complication of pregnancy that we know will happen on average but whose victim we cannot (and they cannot) predict well in advance." *Expanding Consumer Choice and Addressing "Adverse Selection" Concerns in Health Insurance: Hearings Before the Joint Econ. Comm.*, 108th Cong., 2d Sess. 32 (2004) (statement of Mark V. Pauly, Univ. of Pennsylvania). Costs can mount rapidly for treatment of even the most common significant health problems.[3] It is difficult for all, and impossible for many, to budget for such contingencies.

Second, because of the virtually inevitable, yet unpredictable, need for health care services, individuals typically pay for them through insurance. In 2009, payments by private health insurers constituted 32% of na-

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[3] For example, the average cost of an appendectomy in 2010 was $13,123. International Fed'n of Health Plans, *2010 Comparative Price Report: Medical and Hospital Fees By Country*, 14, http://www.ifhp.com/documents/IFHPpricereport151210.pdf. The average cost of a day in the hospital was $3,612; of a hospital stay, $14,427; of a Caesarian-section, $13,016; of bypass surgery, $59,770; of an angioplasty, $29,055. *Id.* at 9, 10, 12, 16, 17. Drug treatment for a common form of cancer costs more than $150,000 a year. Neal J. Meropol et al., *Cost of Cancer Care: Issues and Implications*, 25 J. Clin. Oncol. 180, 182 (2007).

tional health care spending. *National Health Expenditures Data*, Centers for Medicare & Medicaid Servs., table 3 (2011), http://www.cms.gov/NationalHealthExpendData/downloads/tables.pdf. More than 43% of total health care expenditures was financed by federal, state, and local governments, including through insurance programs such as Medicare, the federal program that provides health insurance for elderly and certain disabled Americans, as well as Medicaid. *Id.* tables 5, 11.

Third, many individuals receive, and expect to receive, costly health care services in times of need without regard to their ability to pay for the services. For 25 years, the federal Emergency Medical Treatment and Labor Act (EMTALA) has required hospitals that participate in Medicare and offer emergency services to stabilize any patient who arrives with an emergency condition, regardless of whether the person has insurance or otherwise can pay. 42 U.S.C. 1395dd; see *Roberts* v. *Galen of Va., Inc.*, 525 U.S. 249, 250-251 (1999) (per curiam). Even before enactment of EMTALA, many state legislatures and courts had concluded that hospitals cannot properly turn away people in need of emergency treatment. See, *e.g.*, H.R. Rep. No. 241, 99th Cong., 1st Sess. Pt. 3, at 5 (1985) (in addition to "state court rulings impos[ing] a common law duty on doctors and hospitals to provide necessary emergency care," by 1985, "at least 22 states [had] enacted statutes or issued regulations requiring the provision of limited medical services whenever an emergency situation exists"). The federal Medicare and Medicaid programs provide substantial support for hospitals that incur such uncompensated costs through additional payments for "disproportionate share hospitals," and many States have addi-

tional programs to support hospitals with significant amounts of uncompensated care.

Against the backdrop of these unique and fundamental features of the market for health care services, Congress made specific statutory findings addressing the basis for exercising its powers under Article I of the Constitution. For example, it found that the minimum coverage provision "regulates activity that is commercial and economic in nature: economic and financial decisions about how and when health care is paid for, and when health insurance is purchased." §§ 1501(a)(2)(A), 10106(a), 124 Stat. 243, 907 (to be codified at 42 U.S.C. 18091(a)(2)(A)). Congress concluded that "[i]n the absence of the requirement, some individuals would make an economic and financial decision to forego health insurance coverage and attempt to self-insure, which increases financial risks to households and medical providers." § 10106(a), 124 Stat. 907 (to be codified at 42 U.S.C. 18091(a)(2)(A)). Congress found that the provision will reduce the substantial cost-shifting in the interstate health care market that results from the practice of consuming health care without insurance and that increases the premiums of insured consumers. § 10106(a), 124 Stat. 908 (to be codified at 42 U.S.C. 18091(a)(2)(F)).

In addition, Congress found that the minimum coverage provision is key to the viability of the Act's requirement that insurers provide coverage and charge premiums without regard to a person's medical condition or history. Without a minimum coverage requirement, "many individuals would wait to purchase health insurance until they needed care," which would undermine the effectiveness of insurance markets. §§ 1501(a)(2)(G), 10106(a), 124 Stat. 243, 908 (to be codified at 42 U.S.C.

18091(a)(2)(I)); see, *e.g.*, *47 Million and Counting: Why the Health Care Marketplace is Broken, Hearings Before the Senate Comm. on Fin.*, 110th Cong., 2d Sess. 52 (2008) (statement of Mark A. Hall, Wake Forest Univ.) (a "health insurance market could never survive or even form if people could buy their insurance on the way to the hospital").

2. On March 10, 2010—13 days before enactment of the Affordable Care Act—the Virginia General Assembly passed a statute providing that "[n]o resident of this Commonwealth * * * shall be required to obtain or maintain a policy of individual insurance coverage except as required by a court or the Department of Social Services where an individual is named a party in a judicial or administrative proceeding." Va. Code Ann. § 38.2-3430.1:1 (Supp. 2010). The day the Affordable Care Act was signed into law, petitioner filed suit against respondent, asking the district court to "declare that § 38.2-3430.1:1 is a valid exercise of state power" because the minimum coverage provision was enacted in excess of Congress's enumerated powers. Compl. 6 (prayer for relief).

Respondent moved to dismiss for lack of standing because the minimum coverage provision applies only to individuals, not States like petitioner, and a State does not have *parens patriae* standing to assert the interests of its citizens in a suit against the United States. Pet. App. 58-59 (citing, *inter alia*, *Massachusetts* v. *Mellon*, 262 U.S. 447 (1923)). The district court denied the motion to dismiss. *Id.* at 54-89. The court acknowledged that Virginia's statute was merely "declaratory," but held that petitioner could nonetheless sue the United States "to defend the [statute] from the conflicting effect of an allegedly unconstitutional federal law." *Id.* at 66.

On cross-motions for summary judgment, the district court held that the minimum coverage provision is not a valid exercise of Congress's power under the Commerce Clause or its power to lay and collect taxes. Pet. App. 1-46. In addressing the commerce power, the court did not question Congress's finding that consumption of health care services without insurance imposes a substantial burden on the interstate health care market. § 10106(a), 124 Stat. 908 (to be codified at 42 U.S.C. 18091(a)(2)(F)). Nor did the court question Congress's finding that the minimum coverage provision is instrumental to the Act's provisions that bar insurance companies from denying coverage because of pre-existing medical conditions. §§ 1501(a)(2)(G), 10106(a), 124 Stat. 243, 908 (to be codified at 42 U.S.C. 18091(a)(2)(I)). The district court nonetheless concluded that Congress has authority under the Commerce Clause to regulate only "self-initiated action" and that regulation of the means of payment for health care services does not fall into that category. Pet. App. 28-29. The court reasoned that defining economic activity to include regulation of how people pay for health care, including people who decline to purchase insurance, "lacks logical limitation and is unsupported by Commerce Clause jurisprudence." *Id.* at 29.

Addressing Congress's taxing power, the court recognized that the minimum coverage provision amends the Internal Revenue Code to provide that non-exempted individuals who fail to maintain minimum coverage shall pay a penalty, which is calculated in part by reference to household income, is reported on the individual's federal income tax return for the taxable year, and is assessed and collected in the same manner as certain other federal tax penalties. Pet. App. 32-33. The court

also acknowledged that the Congressional Budget Office projected that this provision will generate billions of dollars of revenue each year that will be paid into the general treasury. *Id.* at 32. Nonetheless, the court held that the provision is not a valid exercise of Congress's taxing power because, in the court's view, the "legislative purpose underlying this provision was purely regulation of what Congress misperceived to be economic activity." *Id.* at 40.

The district court issued a declaratory judgment that the minimum coverage provision is unconstitutional. Pet. App. 52. The court determined that the minimum coverage provision and "directly-dependent provisions which make specific reference" to it are severable from the remainder of the Affordable Care Act, *id.* at 49, and denied injunctive relief, *id.* at 49-50.

3. Both parties appealed, jointly moved for expedited briefing and argument, and asked that the case be heard by the Fourth Circuit on the same day as *Liberty University* v. *Geithner*, No. 10-2347, in which a different district court upheld the constitutionality of the minimum coverage provision against challenge by several uninsured individuals and a non-profit organization. See *Liberty Univ.* v. *Geithner*, No. 6:10-cv-00015-nkm, 2010 WL 4860299 (W.D. Va. Nov. 30, 2010). The Fourth Circuit granted that joint motion and a parallel motion filed in *Liberty University*, and it has scheduled argument in both appeals for May 10.

ARGUMENT

The parties are currently briefing this case in the court of appeals on an expedited basis. The opening brief for the Secretary of Health and Human Services has already been filed in that court (along with 19 amici

briefs), and oral argument is scheduled to be held in approximately 60 days. Especially given the court of appeals' imminent consideration of this case, there is no basis for short-circuiting the normal course of appellate review by granting a writ of certiorari before judgment. Moreover, this case would make a poor vehicle to address the constitutionality of the Affordable Care Act's minimum coverage provision because petitioner's claim to standing rests entirely on a novel "declaratory" state statute (Pet. App. 66), and that threshold jurisdictional question could readily prevent the Court from reaching the merits of petitioner's claim. The petition should be denied.

1. Rule 11 of the Rules of this Court provides that a petition for a writ of certiorari before judgment "will be granted only upon a showing that the case is of such imperative public importance as to justify deviation from normal appellate practice and to require immediate determination in this Court." The constitutionality of the minimum coverage provision is undoubtedly an issue of great public importance. This case is not, however, one of the rare cases that justifies "deviation from normal appellate practice" and "require[s] immediate determination in this Court." Sup. Ct. R. 11.

The constitutionality of the minimum coverage provision is already under expedited review in three courts of appeals, and expedition has been sought in a fourth. The Fourth Circuit will hold argument in this case and in *Liberty University* v. *Geithner*, No. 10-2347, on May 10. The Sixth Circuit will hear oral argument in *Thomas More Law Center* v. *Obama*, No. 10-2388, during its May 30-June 10 sitting. That case presents an appeal from the decision in *Thomas More Law Center* v. *Obama*, 720 F. Supp. 2d 882 (E.D. Mich. 2010), which,

like *Liberty University*, rejected constitutional challenges to the minimum coverage provision. In *Seven-Sky* v. *Holder*, No. 11-5047 (D.C. Cir.), the United States has consented to appellants' request for expedited briefing. That case involves an appeal from the decision in *Mead* v. *Holder*, No. Civ.A. 10-950 GK, 2011 WL 611139 (D.D.C. Feb. 22, 2011), which likewise rejected constitutional challenges to the minimum coverage provision. Like *Liberty University*, the *Thomas More Law Center* and *Seven-Sky* cases involve uninsured individual plaintiffs who will be subject to the minimum coverage provision and whose standing the government does not challenge. In addition, the government has appealed the district court's decision in *Florida ex rel. Bondi* v. *United States Department of Health & Human Services*, No. 3:10-CV-91-RV/EMT, 2011 WL 285683 (N.D. Fla. Jan. 31, 2011), appeal docketed, No. 11-11021 (11th Cir. Mar. 9, 2011), cross-appeal docketed, No. 11-11067 (11th Cir. Mar. 11, 2011).[4] The Eleventh Circuit has expedited proceedings, and the case will be fully briefed on May 25.

Petitioner identifies no persuasive reason for this Court to proceed without the benefit of review by the courts of appeals. Cf. *United States* v. *Mendoza*, 464 U.S. 154, 160 (1984) (Court "benefit[s]" from allowing circuit courts to consider a question "before this Court

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[4] In *Bondi*, the district court held that the minimum coverage provision was in excess of Congress's enumerated powers and that it was inseverable from the rest of the Act. See 2011 WL 285683 at *20-*39. On that basis, the court "declared void" the "entire Act." *Id.* at *40. The court subsequently stayed its decision pending appellate review. See *Florida ex rel. Bondi* v. *United States Dep't of Health & Human Servs.*, No. 3:10-CV-91-RV/EMT, 2011 WL 723117, at *8-*11 (N.D. Fla. Mar. 3, 2011).

grants certiorari."). The minimum coverage provision is the only provision of the Affordable Care Act that petitioner claims is unconstitutional, and it does not take effect until 2014, *i.e.*, for more than two-and-one-half years. Moreover, no court has precluded the government from preparing to implement the Affordable Care Act under the schedule Congress established. There will be ample time before 2014 for this Court to decide whether to grant review in the normal course and, if it does so, to issue a decision.

Indeed, because petitioner has not sought expedition of its request for certiorari before judgment, even were its petition granted, this case would not be heard until next Term. Given the pendency of expedited appeals in three courts of appeals (and a pending request for expedition in a fourth), see pp. 12-13, *supra*, it is possible that one of those cases could be heard next Term in the normal course. See Liberty Univ. Amicus Br. 5-6 (noting that the Fourth Circuit is among the fastest courts of appeals). Accordingly, granting certiorari before judgment in this case would not necessarily result in significantly accelerating this Court's review of the constitutionality of the minimum coverage provision. At the same time, it would have the certain downside of depriving this Court of consideration of these issues by the court of appeals.

2. Petitioner contends that this Court's review is warranted even before the courts of appeals have had the opportunity to address the constitutionality of the minimum coverage provision because petitioner must "devote considerable resources now to meet the requirements of" other provisions of the Affordable Care Act. Pet. 14; see Pet. at 14-16 (discussing alleged present burdens caused by several provisions of the Act other

than the minimum coverage provision). Petitioner has not claimed that *any* of these provisions exceed Congress's constitutional authority, and the district court did not specifically consider, let alone invalidate, them.[5] That petitioner must remain subject to those unchallenged provisions during the relatively short time necessary for orderly appellate review thus does not constitute an extraordinary circumstance warranting certiorari before judgment.

In any event, the petition provides no examples of substantial resources currently devoted to compliance with the Affordable Care Act. For example, petitioner states that it must "assess" whether to exercise the option of developing a health insurance exchange under the Act, which would otherwise be established by the federal government. Pet. 14. Petitioner also cites "complex bills" that were pending before the Virginia General Assembly. *Ibid.* Those bills, which have since been approved by the General Assembly, do not appear to

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[5] Petitioner contends that those provisions already in effect, while not unconstitutional, are inseverable from the one provision it has challenged. The district court properly declined to declare those provisions inseverable. Pet. App. 46-49; see *Free Enter. Fund* v. *Public Co. Accounting Oversight Bd.*, 130 S. Ct. 3138, 3161 (2010) ("Generally speaking, when confronting a constitutional flaw in a statute, we try to limit the solution to the problem, severing any problematic portions while leaving the remainder intact.") (internal quotation marks and citation omitted). In any event, petitioner's sweeping contention (Pet. i) that Congress would not have wanted *any* portion of the Affordable Care Act to remain effective in the event that the minimum coverage provision were invalidated (including even those provisions "patently extraneous to health care," Pet. App. 46) is most clearly wrong with respect to provisions, like those already in effect, that Congress required to become operative before 2014, *i.e.*, years before the minimum coverage provision takes effect.

involve a significant expenditure of resources. For example, the fiscal impact statement accompanying H.B. 2434, Gen. Assemb., Reg. Sess. (Va. 2011), which declares Virginia's intent to establish a health insurance exchange, "specifies no fiscal impact" and states that "[i]t is feasible that the state may be able to design and implement an exchange with available federal grants and no state funding."[6] Notably, petitioner has already received a federal grant for exchange planning,[7] and it is currently eligible to apply for a federal grant to establish an exchange.[8] The fiscal impact statements accompanying H.B. 1928, Gen. Assemb., Reg. Sess. (Va. 2011), which requires insurers to accord policyholders certain appeal rights, and H.B. 1958, Gen. Assemb., Reg. Sess. (Va. 2011), which requires insurers to adhere to other federal requirements, report that those measures also have no fiscal impact.[9]

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[6] See Department of Planning & Budget, *2011 Fiscal Impact Statement, HB 2434*, Va. Gen. Assemb. Legis. Info. Sys., 1 (Jan. 20, 2011), http://leg1.state.va.us/cgi-bin/legp504.exe?111+oth+HB2434F122+PDF.

[7] U.S. Dep't of Health & Human Servs., *Exchange Planning Grants: Grant Awards List*, HealthCare.gov (July 29, 2010), http://www.healthcare.gov/news/factsheets/grantawardslist.html; News Release, *Forty-eight states receive new resources to build competitive health insurance marketplaces*, HHS.gov (Sept. 30, 2010), http://www.hhs.gov/news/press/2010pres/09/20100930b.html.

[8] News Release, *HHS Announces new resources to help states implement Affordable Care Act*, HHS.gov (Jan. 20, 2011), http://www.hhs.gov/news/press/2011pres/01/20110120b.html.

[9] See State Corp. Comm'n, *2011 Fiscal Impact Statement, HB 1928*, Va. Gen. Assemb. Legis. Info. Sys., 1 (Feb. 22, 2011), http://leg1.state.va.us/cgi-bin/legp504.exe?111+oth+HB1928FER171+PDF; State Corp. Comm'n, *2011 Fiscal Impact Statement, HB 1958*, Va. Gen.

3. This case does not resemble the handful of cases in which this Court has taken the extraordinary step of granting certiorari before judgment. See Pet. 16-17, 18 (citing cases). The Court did not grant certiorari before judgment in those cases because the issues they presented "must be and will be decided in this Court," Pet. 16, but instead because of extraordinary circumstances, not present here, warranting this Court's immediate intervention outside the normal course of appellate review. In most of the cases petitioner cites, this Court granted early review because allowing review to proceed in the normal course presented risks of extraordinary disruption and irreparable harm.

For example, in *Mistretta* v. *United States*, 488 U.S. 361 (1989), the Court granted petitions for certiorari before judgment filed by both the United States and a criminal defendant to decide the constitutionality of the federal Sentencing Guidelines. *Id.* at 371. At the time of the government's petition in that case, 50 different district courts had decided the question (dividing 29-21), and further delay in final resolution of the question would have required that thousands of criminal defendants be resentenced. Pet. at 9-11, 14, *Mistretta*, *supra* (No. 87-1904). Likewise, the United States filed a petition for a writ of certiorari before judgment in *United States* v. *United Mine Workers*, 330 U.S. 258 (1947), because, absent immediate resolution by this Court, an ongoing strike at the nation's bituminous coal mines (then being operated by the United States) threatened "a decline in total employment of at least 5,000,000 full time workers" and a decline in annual national income of

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Assemb. Legis. Info. Sys., 1 (Feb. 25, 2011), http://leg1.state.va.us/cgi-bin/legp504.exe?111+oth+HB1958FER171+PDF.

$20 billion. Pet. at 21, *United Mine Workers*, *supra* (Nos. 46-759, 46-760). The United States petitioned for a writ of certiorari before judgment (and acquiesced in a petition filed by a private party) in *Carter* v. *Carter Coal Co.*, 298 U.S. 238 (1936), because a number of district courts had enjoined collection of federal taxes under the Bituminous Coal Conservation Act of 1935, 15 U.S.C. 801 *et seq.* See U.S. Mem. at 2, *Carter Coal*, *supra* (No. 35-636); see also *Youngstown Sheet & Tube Co.* v. *Sawyer*, 343 U.S. 579, 584 (1952) (Court granted petitions for certiorari before judgment filed by the United States and a private party to review legality of federal government's ongoing seizure of the nation's steel industry); Pet. at 6, 7, *Railroad Ret. Bd.* v. *Alton R.R.*, 295 U.S. 330 (1935) (No. 34-566) (United States sought certiorari before judgment because district court had enjoined operation of federal statute "which directly affect[ed] over 1,000,000 employees and all interstate commerce carriers by railway").

Other examples cited by petitioner were cases in which the Court granted certiorari before judgment either because the case had previously been before it at an earlier stage of the proceedings[10] or because the Court had already granted review (in the normal course) in

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[10] See *St. Louis, Kan. City & Colo. R.R.* v. *Wabash R.R.*, 217 U.S. 247, 249, 251 (1910) (certiorari before judgment granted where "question involve[d] the construction of a prior decree of a United States Circuit Court, affirmed by this court"); see also James Lindgren & William P. Marshall, *The Supreme Court's Extraordinary Power to Grant Certiorari Before Judgment in the Court of Appeals*, 1986 Sup. Ct. Rev. 259, 270 (explaining grant of certiorari in *St. Louis Railroad* on that basis).

another case presenting the same or a similar issue.[11] Neither of those circumstances is presented here.

4. Even assuming *arguendo* that the standards for certiorari before judgment were otherwise satisfied in this case, this petition should be denied because of a threshold standing question that could readily prevent the Court from reaching the merits.

Virginia has claimed that only one provision of the Affordable Care Act is unconstitutional: the minimum coverage provision. That provision applies only to individuals and imposes no duties on Virginia or other States. Insofar as Virginia asserts any cognizable rights, they are the purported rights of its residents not to be subject to the minimum coverage provision. This Court's precedents, however, foreclose a suit by a State against the federal government "to protect her citizens from the operation of federal statutes." *Massachusetts* v. *EPA*, 549 U.S. 497, 520 n.17 (2007); see also *Alfred L. Snapp & Son, Inc.* v. *Puerto Rico*, 458 U.S. 592, 610 n.16 (1982) ("[a] State does not have standing as *parens*

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[11] See *Gratz* v. *Bollinger*, 539 U.S. 244, 259-260 (2003) (Court granted certiorari before judgment because addition of second case to one already pending would permit Court to "address the constitutionality of the consideration of race in university admissions in a wider range of circumstances"); *New Haven Inclusion Cases*, 399 U.S. 392, 418 (1970) (certiorari before judgment granted because Court had noted probable jurisdiction under its appellate jurisdiction in closely related case); *Porter* v. *Dicken*, 328 U.S. 252, 254 (1946) (certiorari before judgment granted because of "the close relationship of the important question raised to the question presented in" another case in which certiorari had been granted in the normal course); *United States* v. *Bankers Trust Co.*, 294 U.S. 240, 243 (1935) (Court granted United States' petition for certiorari before judgment where another case presenting same issue was already pending before the Court); see U.S. Pet. at 4, *Bankers Trust Co.*, *supra* (Nos. 34-471, 34-472).

patriae to bring an action against the Federal Government") (citing *Massachusetts* v. *Mellon*, 262 U.S. 447, 485-486 (1923), and *Missouri* v. *Illinois*, 180 U.S. 208, 241 (1901)).

Petitioner attempts to circumvent this longstanding limitation on state standing to sue the United States by relying on Virginia Code Annotated § 38.2-3430.1:1 (Supp. 2010), which was enacted shortly before the Affordable Care Act was signed into law. That state statute declares that no Virginia resident "shall be required to obtain or maintain a policy of individual insurance coverage except as required by a court or the [Virginia] Department of Social Services." *Ibid.* It grants the Commonwealth and its Attorney General no power of enforcement, and petitioner has not suggested that the statute serves any function other than as an effort to create standing in this case that petitioner indisputably would otherwise lack. Indeed, the statute exempts entities other than the federal government, allowing a higher education institution, for example, to require health insurance as a condition of enrollment. *Ibid.*

Nonetheless, the district court, while acknowledging that the state statute is wholly "declaratory," reasoned that petitioner may bring this suit "to defend the Virginia Health Care Freedom Act from the conflicting effect of an allegedly unconstitutional federal law." Pet. App. 66. Contrary to the district court's reasoning, however, petitioner cannot avoid the bar to a State's standing to assert the rights of its citizens in a suit against the United States by enacting a statute that codifies its legal claim. Regardless of whether petitioner's disagreement with federal law is framed in a complaint or proclaimed in a legislative declaration, its suit impermissibly calls upon the courts "to adjudicate, not rights of person or

property, not rights of dominion over physical domain, not quasi-sovereign rights actually invaded or threatened, but abstract questions of political power, of sovereignty, of government." *Mellon*, 262 U.S. at 484-485; see also *New Jersey* v. *Sargent*, 269 U.S. 328, 337 (1926) (allegation that provisions of federal law "go beyond the power of Congress and impinge on that of the State * * * do not suffice as a basis for invoking an exercise of judicial power").

Comparison with cases in which this Court has found state standing in actions against the federal government demonstrates that this case is not justiciable. For example, in *Massachusetts* v. *EPA*, the Court held that the State could challenge EPA's failure to regulate greenhouse gas emissions because "rising seas," caused in part by these emissions, would injure Massachusetts "in its capacity as a landowner" and "have already begun to swallow Massachusetts' coastal land." 549 U.S. at 522-523. A State likewise may challenge a measure that commands the State itself to take action, *e.g.*, *New York* v. *United States*, 505 U.S. 144 (1992) (federal law required state to take title to nuclear waste or enact federally approved regulations), or that prohibits specified state action, *e.g.*, *Oregon* v. *Mitchell*, 400 U.S. 112 (1970) (federal law prohibited States from using literacy tests or durational residency requirements in elections).

This case challenging the minimum coverage provision has none of those features, and a State cannot convert a "naked contention that Congress has usurped the reserved powers of the several States," *Mellon*, 262 U.S. at 483, into a justiciable controversy by passing a statute that declares federal law unenforceable against the citizens of that State. This Court stressed in *Massachusetts* v. *EPA* that "there is a critical difference between

allowing a State 'to protect her citizens from the operation of federal statutes' (which is what *Mellon* prohibits) and allowing a State to assert its rights under federal law (which it has standing to do)." 549 U.S. at 520 n.17 (quoting *Georgia* v. *Pennsylvania R.R.*, 324 U.S. 439, 447 (1945)); see *id.* at 547 (Roberts, C.J., dissenting) (States do not have standing to pursue "symbolic" litigation because "[t]he constitutional role of the courts * * * is to decide concrete cases—not to serve as a convenient forum for policy debates"). The only objective of the Virginia statute is "to protect her citizens from the operation of federal statutes." *Massachusetts* v. *EPA*, 549 U.S. at 520 n.17. This Court's precedents thus foreclose petitioner's invitation to adjudicate the "antagonistic assertions of right," Compl. ¶ 4, that are the sole basis for this suit.

Respondent has challenged petitioner's standing on these grounds before the court of appeals, see Gov't C.A. Br. 24-30, and this Court would benefit from having that court's considered views on the standing question before deciding whether to grant review in this case.

CONCLUSION

The petition for a writ of certiorari before judgment should be denied.

Respectfully submitted.

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